STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019610	A. BUILDING: _____ B. WING _____	R-C 06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LILY MEADOWS	N6581 VILLA PKWY WESTFIELD, WI 53964

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 000}	Initial Comments On 06/11/2025, Surveyor conducted an onsite visit at Lily Meadows to investigate two complaints, verify correction of two previous deficiencies and review one self-reported incident. Two (2) of 2 complaints were unsubstantiated. Two (2) of 2 previous deficiencies were corrected. One (1) new deficiency was identified. Census: 32 Under statutory provisions of WI Stat. Ch. 50 a $200 revisit fee is being assessed.	{N 000}		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1 received prescribed warfarin on 10/26/2024 and 10/27/2024. During the early morning hours of 10/28/2024, Resident 1 suffered a stroke. Findings include: On 10/28/2025 the provider submitted a self-report regarding a medication error for Resident 1.	N 352		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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N 352	Continued From page 1 On 06/12/2025, Surveyor reviewed portions of Resident 1's record. Resident 1 was admitted 05/09/2024. The record documented long term use of anticoagulants (blood thinners) and diagnoses to include atrial fibrillation and hyperlipidemia (high cholesterol, increases risk of stroke). Resident 1 relied on staff assistance for medication management and administration. Resident 1 was prescribed warfarin and dosing was based on the results of routine INR testing. INR testing "measures how quickly your blood clots" and may be used to "Monitor how warfarin...is working. Warfarin is a blood thinner that prevents dangerous blood clots. Without treatment, people at risk for blood clots can develop serious conditions such as deep venous thrombosis or pulmonary embolism." Source: https://my.clevelandclinic.org/health/diagnostics/prothrombin-time-test, retrieval date 06/12/2025. On 10/25/2024, the provider received a new order for warfarin which read, "HOLD Warfarin [sic] on (Friday) 10/25/24 - give warfarin 2 mg on Saturday and Sunday - Repeat INR on 10/28/24" Surveyor reviewed 2 incident reports, observation notes and a medication error investigation report and noted the following: 10/28 at 1:34 AM - "During rounds Resident was breathing but unable to communicate. Resident had no strength on the right side while the left side appeared slightly stronger. 911 was called at 1:36...EMS arrived at 1:50 and transported resident to (the) hospital." 10/28 at 7:15 AM - "Writer determined that this resident did not receive [his/her] scheduled warfarin on both 10/26/24 and 10/27/24...staff did	N 352		

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N 352	Continued From page 2 not pass the medication as it was not in the med cart drawer and they failed to check the medication room for a delivery from...pharmacy." 10/28 at 9:45 AM - "admitted to hospital for suspected CVA (stroke)." Error Investigation Findings - "Medication delivered to facility on Sat 10/26. Med not given on Saturday or Sunday. They were left in the paper bag from (the) pharmacy in the med room." 10/29 - family reported "more than likely won't be coming back to our facility...[s/he] had a stroke...is paralyzed on [his/her] right side..." 11/07 - family reported "is on...hospice end of life." Surveyor interviewed Manager C and Manager G at 10:43 AM. They confirmed Surveyor's review of the record. Manager C said Resident 1 was "prone to strokes." Manager C and Manager G said a former facility nurse investigated the incident and they were unsure why the warfarin was not put in the medication cart when it was delivered. Manager C and Manager G said re-education was provided to staff on the importance of a medication like warfarin and their process of contacting the on call facility nurse if a medication is not available. Manager C provided Surveyor with documentation to verify the re-education occurred.	N 352		